If you have Medicaid, you do not need to fill out this form.

For Office Use Only

DATE STAMP

❑ NEW APPLICATION

❑ RENEWAL APPLICATION

Maryland Department of Health and Mental Hygiene

Maryland Children's Health Program (MCHP)

Application Instructions:

- ✓ **Complete the application honestly and completely.**
- ✓ **Print all answers clearly.**
- ✓ **Fill in all boxes. If no answer, write "None" in the box.**

1. Tell Us Who You Are And Where You Live.

Last Name (Parent/Guardian)	First Name	M.I (Jr., Sr.)	Day-Time Telephone Number	Family's Primary Language:	Married? ❑ NO ❑ YES
Home Address (Include Apartment/Lot Number)	City	State	Zip Code		Have you ever used another name? ❑ NO ❑ YES
Mailing Address (If Different From Above)	City	State	Zip Code		If Yes, list other names:

2. Tell Us About The People Living In The Household. Check each child or pregnant woman applying for MCHP.

NOTE: Social Security numbers given will not be shared with the Immigration and Naturalization Service (INS).

Office Use Only	Are you applying for MCHP for this person?	Last Name	First Name	How is this person related to you?	Date of Birth Month Day Year	Sex ÿM ÿF	Race Caucasian Asian African-Amer Hispanic Amer-Indian /Alaskan - Native Other	Social Security Number ***Needed for MCHP applicants only; Optional for others in household and MCHP Premium.***
	ÿYES ÿ NO			**SELF**		ÿM ÿF		
	ÿYES ÿ NO			ÿChild ÿStep-child ÿSpouse ÿOther		ÿM ÿF		
	ÿYES ÿ NO			ÿChild ÿStepChild ÿSpouse ÿOther		ÿM ÿF		
	ÿYES ÿ NO			ÿChild ÿStepChild ÿSpouse ÿOther		ÿM ÿF		
	ÿYES ÿ NO			ÿChild ÿStepChild ÿSpouse ÿOther		ÿM ÿF		
	ÿYES ÿ NO			ÿChild ÿStepChild ÿSpouse ÿOther		ÿM ÿF		

3. Is anyone applying for MCHP in your household pregnant? š YES Ÿ NO

Name of Person Who Is Pregnant	Due Date	Single Baby? Twins? Triplets?

4. Tell Us If Anyone Applying For MCHP (Child or Pregnant Woman) Has Any Unpaid Medical Bills For Services Received In The Past Three (3) Months.
Examples of unpaid medical bills would include doctor's visits, hospitalization, medical tests, prescriptions, equipment, etc.

4A. Do you want MCHP to help with these unpaid bills? **ȳ YES ȳ NO**	4B. Tell us who received medical care and when. **Name**	**Month/Year**

5. Tell Us If Anyone Applying For MCHP Has Other Related Medical Expenses. Fill out the following information if anyone applying for MCHP has medical expenses that are a result of an accident, job injury or malpractice, or is expecting to receive an accident settlement, trust fund, inheritance or other money or property.

Name of Injured Person	Date of Accident/Injury
Name and Address of Other Persons or Companies That May Be Liable	
Money or Property Expected	Name, Address and Telephone No. of Attorney Involved

6. If The Child Applying For MCHP Is Not Eligible For Free Medical Care:

Would you (the parent or guardian of the applicant) be willing to pay part of the cost for health insurance coverage through MCHP Premium? **ȳ YES ȳ NO**

Does the employer of the child's parent or guardian offer health insurance coverage for children? **ȳ YES ȳ NO**

7. Does Anyone Applying For MCHP Have Any Health Insurance? ȳ YES ȳ NO

If Yes, answer the following:

Name of Policy Holder _____ Name of Person(s) covered _____
Name

Insurance Company Name _____ Policy Number _____

Group#_____ Effective Date _____ End Date _____

Have you dropped employer-based health insurance coverage for the applicant within twelve (12) months of filing this application for MCHP? **ȳ YES ȳ NO**

If yes, please tell us when and why coverage was dropped: 0-3 months ÿ 4-6 months ÿ 7-9 months ÿ 10-12 months

ÿ Changed Employer ÿ Terminated From Job ÿ Employer dropped coverage ÿ COBRA Coverage Ended ÿ No Longer Needed ÿ Quit Job
ÿ Cost ÿ Moved Out of Service Area Of Employer's Health Plans ÿ Dropped Limited Benefit Insurance (Vision, Dental, Not Hospital) ÿ Other: _____

8. Tell Us About Family Income.

A. **Earned Income.** List any wages, tips, commissions, earnings or money from self-employment. For child applicants, we count the parents' income for children if living together. We count income from your child's brothers and sisters living in the household if you choose to include them. For pregnant women of any age, we count the pregnant woman's income and the income of her spouse, if married and living together.

We don't count income from other adults in the household (grandparents, aunts, and uncles).

Name of Employed Person	Name of Employer	Address of Employer Street, City, State, Zip Code	Telephone #	Gross Amount Paid (before taxes)	How Often Paid? weekly biweekly monthly bimonthly quarterly annually	Job End Date	Student Status (Full or part-time)

B. Unearned Income. List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

Person Receiving Income	Type (For Benefits, Include Claimant ID #)	Amount Received	How Often?

9. Tell Us If You Pay For Child Care, Child Support Or Alimony. These expenses lower the amounts of income we count and may help you become eligible.

Name of Child Care Provider or Day Care Center	Telephone #	Name(s) of Child(ren) Cared For	Cost	Who Pays For This Child?
			$ PER	
			$ PER	
Do you have Purchase of Care Services/Vouchers through the Department of Social Services? ÿ YES ÿ NO				

Name of Person Paying Child Support or Alimony	Name of Person to Whom Child Support or Alimony Is Paid	Amount Paid	How Often?

10. Other Information

The Maryland Children's Health Program would like to know how you found out about our program. ÿ Friend ÿ Family ÿ School ÿ Community Organization ÿ Doctor/Health Care Professional ÿ Advertisement ÿ Other _____	If anyone in your household is not registered to vote, would they be interested in receiving voter registration forms? ÿ YES ÿ NO

Here are your rights and responsibilities under the Maryland Children's Health Program.
Please read these carefully before signing below.

Health Care Benefits I know I have the right to request and, if found eligible, to receive MCHP benefits based on policies and standards established under Maryland law.

Confidentiality I understand that the information I have given is confidential. I agree that medical information about my children or me can be released when the law allows.

Social Security Number (SSN) I understand that providing the SSNs of MCHP applicants is required and that providing the social security numbers of other household members and MCHP Premium applicants is voluntary. I will not be penalized if the SSNs of household members who are not applying for MCHP or the SSNs of MCHP Premium applicants are not provided. SSNs will not be shared with Immigration and Naturalization Services (INS), and will only be used to help check the information about income and insurance coverage and to help maintain eligibility files. If I do not have a SSN and want to apply for one, I understand that my case manager will help me.

Personal and Financial Information I agree to the release of personal and financial information from this application form to the agencies determining eligibility. I give permission for officials of the Maryland Children's Health Program to verify all information on this form. I understand I may be asked to provide additional information.

Third Party Payments And Cooperation With Quality Control Review I understand that I am required by law to assign to the State all rights to third party payments (hospital and medical benefits) and to cooperate with the State's Medical Assistance quality control review process including verification of all information pertinent to the determination of eligibility.

Reporting Changes I have a responsibility to report all changes that might affect eligibility within ten (10) days of the change. Examples of changes I must report are changes in number of people in the household, address, income, employment and pregnancy. I can report changes in person, by telephone, or by mail to my case manager at my local health department or at the Department of Health and Mental Hygiene.

Rights I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief. I know that I may request a hearing if I believe the State of Maryland in processing my application has made an error or if I feel I have been discriminated against. I have the right to appeal any action taken by the Department. If I ask for a hearing, my case manager can help me put my request in writing. At my hearing, I can speak for myself or have someone else represent me. I have a right to a written notice of all decisions affecting my eligibility.

Please sign this statement.
I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Maryland to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities. I know that I can be penalized if I knowingly give false information. I certify that the children and pregnant woman for whom I am applying are U.S. citizens or lawful immigrants or are applying for emergency services only.

Signature:_____ **Date:** _____.